		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022889

Facility Name: FRANKFORT TERRACE

Address: 40 N. SMITH ST. (Number) FRANKFORT (City) 60423 (Zip Code)

County: WILL

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883294

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	37,913	3,709	680	42,302	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,913	3,709	680	42,302	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.58%

D. How many bed-hold days during this year were paid by Public Aid?
728 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	140,489	11,135	5,940	157,564		157,564		157,564			1
2	Food Purchase		155,294		155,294		155,294	(789)	154,505			2
3	Housekeeping	120,045	12,158		132,203		132,203		132,203			3
4	Laundry	63,381	19,668	4,078	87,127		87,127		87,127			4
5	Heat and Other Utilities			119,395	119,395		119,395	269	119,664			5
6	Maintenance	47,203	8,581	21,985	77,769		77,769	4,869	82,638			6
7	Other (specify):*			7,349	7,349		7,349	82	7,431			7
8	**TOTAL General Services**	371,118	206,836	158,747	736,701		736,701	4,431	741,132			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,043,370	58,944	10,859	1,113,173		1,113,173		1,113,173			10
10a	Therapy	121,799		4,310	126,109		126,109		126,109			10a
11	Activities	81,329	3,485	1,836	86,650		86,650		86,650			11
12	Social Services			1,556	1,556		1,556		1,556			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,246,498	62,429	21,561	1,330,488		1,330,488		1,330,488			16
	C. General Administration											
17	Administrative	94,177		342,250	436,427		436,427	(306,659)	129,768			17
18	Directors Fees											18
19	Professional Services			50,936	50,936		50,936	5,874	56,810			19
20	Dues, Fees, Subscriptions & Promotions			18,955	18,955		18,955	(10,852)	8,103			20
21	Clerical & General Office Expenses	69,053	8,602	138,289	215,944		215,944	(100,662)	115,282			21
22	Employee Benefits & Payroll Taxes			319,046	319,046		319,046	(1,460)	317,586			22
23	Inservice Training & Education			1,108	1,108		1,108	50	1,158			23
24	Travel and Seminar							53	53			24
25	Other Admin. Staff Transportation			31,857	31,857		31,857	388	32,245			25
26	Insurance-Prop.Liab.Malpractice			95,224	95,224		95,224	1,524	96,748			26
27	Other (specify):*			73,503	73,503		73,503	(68,030)	5,473			27
28	**TOTAL General Administration**	163,230	8,602	1,071,168	1,243,000		1,243,000	(479,774)	763,226			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,780,846	277,867	1,251,476	3,310,189		3,310,189	(475,343)	2,834,846			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FRANKFORT TERRACE #0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			38,963	38,963		38,963	(8,948)	30,015			30
31	Amortization of Pre-Op. & Org.			697	697		697		697			31
32	Interest			132,692	132,692		132,692	(49,993)	82,699			32
33	Real Estate Taxes			49,937	49,937		49,937	743	50,680			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			31,416	31,416		31,416	2,723	34,139			35
36	Other (specify):* OFFICE RENT			9,210	9,210		9,210	(9,210)				36
37	TOTAL Ownership			262,915	262,915		262,915	(64,685)	198,230			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			65,700	65,700		65,700		65,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,780,846	277,867	1,580,091	3,638,804		3,638,804	(540,028)	3,098,776			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(10,036)	30		9
10	Interest and Other Investment Income	(51,252)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(789)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(10,436)	20		20
21	Owner or Key-Man Insurance	(1,460)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(73,503)	27		24
25	Fund Raising, Advertising and Promotional		20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,241)	20		28
29	Other-Attach Schedule	(40,925)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (189,642)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(350,386)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (350,386)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (540,028)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FRANKFORT TERRACE

ID# 0022889

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2,844	6	1
2	STAFF DEVELOPMENT	(43,769)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,925)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(789)	0	0	0	0	0	0	0	0	0	0	(789)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	269	0	0	0	0	0	0	0	269	5
6	Maintenance	2,844	0	1,560	465	0	0	0	0	0	0	0	4,869	6
7	Other (specify):*	0	0	82	0	0	0	0	0	0	0	0	82	7
8	**TOTAL General Services**	2,055	0	1,642	734	0	0	0	0	0	0	0	4,431	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(312,682)	6,023	0	0	0	0	0	0	0	0	(306,659)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	175	5,530	169	0	0	0	0	0	0	0	5,874	19
20	Fees, Subscriptions & Promotions	(11,677)	0	825	0	0	0	0	0	0	0	0	(10,852)	20
21	Clerical & General Office Expenses	(43,769)	5,525	(62,502)	84	0	0	0	0	0	0	0	(100,662)	21
22	Employee Benefits & Payroll Taxes	(1,460)	0	0	0	0	0	0	0	0	0	0	(1,460)	22
23	Inservice Training & Education	0	0	50	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	53	0	0	0	0	0	0	0	0	53	24
25	Other Admin. Staff Transportation	0	308	80	0	0	0	0	0	0	0	0	388	25
26	Insurance-Prop.Liab.Malpractice	0	670	786	68	0	0	0	0	0	0	0	1,524	26
27	Other (specify):*	(73,503)	1,693	3,780	0	0	0	0	0	0	0	0	(68,030)	27
28	**TOTAL General Administration**	(130,409)	(304,311)	(45,375)	321	0	0	0	0	0	0	0	(479,774)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(128,354)	(304,311)	(43,733)	1,055	0	0	0	0	0	0	0	(475,343)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FRANKFORT TERRACE # 0022889 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(10,036)	222	296	570	0	0	0	0	0	0	0	(8,948)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,252)	0	0	1,259	0	0	0	0	0	0	0	(49,993)	32
33	Real Estate Taxes	0	0	0	743	0	0	0	0	0	0	0	743	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	780	1,807	136	0	0	0	0	0	0	0	2,723	35
36	Other (specify):*	0	0	0	(9,210)	0	0	0	0	0	0	0	(9,210)	36
37	**TOTAL Ownership**	(61,288)	1,002	2,103	(6,502)	0	0	0	0	0	0	0	(64,685)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(189,642)	(303,309)	(41,630)	(5,447)	0	0	0	0	0	0	0	(540,028)	45

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSLT
				EMI REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 322,500	EMI ENTERPRISES		$	$ (322,500)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				9,818	9,818	4
5	V	19	ACCOUNTING FEES				175	175	5
6	V	21	OFFICE EXPENSE				5,525	5,525	6
7	V	25	TRANSPORTATION				308	308	7
8	V	26	INSURANCE				670	670	8
9	V	27	EMPLOYEE BENEFITS				1,693	1,693	9
10	V	30	DEPRECIATION				222	222	10
11	V	35	AUTO LEASE				780	780	11
12	V								12
13	V								13
14	Total			$ 322,500			$ 19,191	$ * (303,309)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 82,080	EKS MANAGEMENT, INC.		$	$ (82,080)	15
16	V								16
17	V								17
18	V	6	PAINTERS SALARIES				1,560	1,560	18
19	V	7	SCAVENGER				82	82	19
20	V	17	CFO SALARY				6,023	6,023	20
21	V	19	PROFESSIONAL FEES				5,530	5,530	21
22	V	20	WANT ADS/BACKGR CKS				825	825	22
23	V	21	OFFICE EXPENSE				19,578	19,578	23
24	V	23	SEMINARS				50	50	24
25	V	24	IN-STATE LODGING/MEALS				53	53	25
26	V	25	TRANSPORTATION				80	80	26
27	V	26	INSURANCE				786	786	27
28	V	27	EMPLOYEE BENEFITS				3,780	3,780	28
29	V	30	DEPRECIATION				296	296	29
30	V	35	EQUIPMENT RENT				1,807	1,807	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,080			$ 40,450	$ * (41,630)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36		$ 9,210	IME REALTY CORP		$	$ (9,210)	15
16	V								16
17	V								17
18	V	5	UTILITIES				269	269	18
19	V	6	REPAIRS/MAINT				465	465	19
20	V	19	PROFESSIONAL FEES				169	169	20
21	V	21	OFFICE EXPENSE				84	84	21
22	V	26	INSURANCE				68	68	22
23	V	30	DEPRECIATION				570	570	23
24	V	32	INTEREST				1,259	1,259	24
25	V	33	RE TAX				743	743	25
26	V	35	STORAGE FEES				136	136	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,210			$ 3,763	$ * (5,447)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION					MANAG. FEE	$ 19,750	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY	9,818	17-7	2
3	AVRUM WEINFELD	CFO	ADMINISTRATION					SALARY	6,023	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 35,591		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 674-1946
Fax Number: ((847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	42,302	$ 9,818	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		42,302	175	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	42,302	5,525	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		42,302	308	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		42,302	670	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		42,302	1,693	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		42,302	222	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		42,302	780	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 19,191	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 674-1946
Fax Number: ((847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTERS SALARIES	PATIENT DAYS	797,100	13	$ 29,397	$	42,302	$ 1,560	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		42,302	82	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	42,302	6,023	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205	93,812	42,302	5,530	4
5	20	WANT ADS/BACKGR CKS	PATIENT DAYS	797,100	13	15,548		42,302	825	5
6	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	368,910	256,444	42,302	19,578	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		42,302	50	7
8	24	IN-STATE LODGING/MEALS	PATIENT DAYS	797,100	13	994		42,302	53	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		42,302	80	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		42,302	786	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		42,302	3,780	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		42,302	296	12
13	35	EQUIPMENT RENT	PATIENT DAYS	797,100		34,056		42,302	1,807	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 463,755		$ 40,450	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 674-1946
Fax Number: ((847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	268,762	13+ FACIL	$ 7,839	$	9,210	$ 269	1
2	6	REPAIRS/MAINT	RENTAL INCOME	268,762	13+ FACIL	13,572		9,210	465	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	268,762	13+ FACIL	4,925		9,210	169	3
4	21	OFFICE EXPENSE	RENTAL INCOME	268,762	13+ FACIL	2,448		9,210	84	4
5	26	INSURANCE	RENTAL INCOME	268,762	13+ FACIL	1,978		9,210	68	5
6	30	DEPRECIATION	RENTAL INCOME	268,762	13+ FACIL	16,647		9,210	570	6
7	32	INTEREST	RENTAL INCOME	268,762	13+ FACIL	36,747		9,210	1,259	7
8	33	RE TAX	RENTAL INCOME	268,762	13+ FACIL	21,685		9,210	743	8
9	35	STORAGE FEES	RENTAL INCOME	268,762	13+ FACIL	3,962		9,210	136	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 3,763	25

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LASALLE BANK		X	MORTGAGE		11/01/01	$ 2,218,297	$ 2,156,944			$ 123,163	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITOL				114,200			9,529	6
7	RELATED PARTY	X									1,259	7
8												8
9	TOTAL Facility Related						$ 2,218,297	$ 2,271,144			$ 133,951	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,218,297	$ 2,271,144			$ 133,951	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 49,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 49,637	2
3. Under or (over) accrual (line 2 minus line 1).		$ (163)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 50,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For _____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 49,937	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	45,902	8
	1998	47,210	9
	1999	49,531	10
	2000	49,316	11
	2001	49,637	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FRANKFORT TERRACE COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0022889

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-21-410-007-0000	NURSING HOME	$ 3,419.00	$ 3,419.00
2.	19-09-21-410-021-0000	" " "	$ 46,218.00	$ 46,218.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 49,637.00	$ 49,637.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,373 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1972	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8	REL PARTY					570		570			8
	Improvement Type**										
9	BUILDING IMPROVEMENTS			1980	7,438		5			7,438	9
10	BUILDING IMPROVEMENTS			1981	3,000		15			3,000	10
11	BUILDING IMPROVEMENTS			1983	3,138		5			3,138	11
12	BUILDING IMPROVEMENTS			1987	8,474	269	31.5	269		4,158	12
13	BUILDING IMPROVEMENTS			1988	51,503	1,635	31.5	1,635		24,457	13
14	BUILDING IMPROVEMENTS			1988	13,056	415	31.5	415		5,974	14
15	BUILDING IMPROVEMENTS			1990	6,944	220	31.5	220		2,766	15
16	BUILDING IMPROVEMENTS			1992	21,890	695	31.5	695		7,254	16
17	BUILDING IMPROVEMENTS			1993	4,065	129	31.5	129		1,252	17
18	BUILDING IMPROVEMENTS			1993	24,826	636	39	636		5,876	18
19	BUILDING IMPROVEMENTS			1994	7,630	196	39	196		1,643	19
20	FLOORING			1995	4,350	112	39	112		863	20
21	ROOFING			1995	10,000	256	39	256		1,931	21
22	FLOORING			1995	1,712	44	39	44		324	22
23	ROOFING			1995	5,200	133	39	133		970	23
24	FLOORING			1995	14,193	364	39	364		2,563	24
25	PARKING LOT LIGHT			1996	5,700	380	15	380		2,470	25
26	ROOFING			1996	10,330	265	39	265		1,834	26
27	LANDSCAPE			1997	6,700	447	15	447		2,458	27
28	DOOR ALARM			1997	1,980	51	39	51		270	28
29	SHOWER			1997	1,660	43	39	43		220	29
30	TILE			1998	6,250	160	39	160		794	30
31	FLOORING			1998	2,650	68	39	68		332	31
32	AWNING			1999	3,530	235	15	235		823	32
33	FLOORING			1999	4,700	121	39	121		459	33
34	CARPET/COVE BASE			2000	11,042	1,931	20	552	(1,379)	1,143	34
35	ROOFTOP AC			2000	2,490	91	27.5	91		186	35
36	VERTICAL BLINDS			2001	974	244	20	49	(195)	98	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CUBICLE CURTAINS	2001	$ 19,810	$ 4,846	20	$ 991	$ (3,855)	$ 1,982	37
38	ROOF REPAIR	2001	4,450	162	27.5	162		317	38
39	FLOOR TILE	2001	18,654	678	27.5	678		967	39
40	ROOFTOP HEAT COOL	2001	1,734	63	27.5	63		92	40
41	CARPET	2002	2,485	45	27.5	45		45	41
42	ROOF VENTILATOR	2002	1,155	21	27.5	21		21	42
43	WINDOW	2002	1,055	19	27.5	19		19	43
44	FENCE	2002	8,986	141	27.5	141		141	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,536,754	$ 15,685		$ 10,256	$ (5,429)	$ 1,321,278	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 192,407	$ 20,724	$ 18,886	$ (1,838)	5-10 YRS	$ 100,664	71
72	Current Year Purchases	7,100	3,124	355	(2,769)	10	355	72
73	Fully Depreciated Assets	337,831					337,831	73
74	RELATED PARTY		518	518				74
75	TOTALS	$ 537,338	$ 24,366	$ 19,759	$ (4,607)		$ 438,850	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,174,092	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,051	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,015	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (10,036)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,760,128	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 21,474 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT. ACTIVITY	01 CHEVY EXP VAN	$ 700.00	$ 8,195	17
18		99 FORD	223.00	1,747	18
19					19
20					20
21	TOTAL		$ 923.00	$ 9,942	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	N/A	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 34,058	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 73,503)	613,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	72,862		6
7	Other Prepaid Expenses	7,302		7
8	Accounts Receivable (owners or related parties)	488,466		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,216,296	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	1,058,563		11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	303,754		15
16	Equipment, at Historical Cost	537,338		16
17	Accumulated Depreciation (book methods)	(1,827,111)		17
18	Deferred Charges	16,378		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,421,922	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,638,218	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 100,614	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	114,200		29
30	Accrued Salaries Payable	58,095		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,411		31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,100		32
33	Accrued Interest Payable	10,470		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 355,890	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,156,944		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,156,944	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,512,834	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 125,384	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,638,218	$	48

***(See instructions.)**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 129,189	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 129,189	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	48,861	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(52,666)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,805)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 125,384	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,636,413	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,636,413	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51,252	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,252	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,687,665	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	736,701	31
32	Health Care	1,330,488	32
33	General Administration	1,243,000	33
	B. Capital Expense		
34	Ownership	262,915	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,638,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	48,861	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 48,861	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,097	$ 55,456	$ 26.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,818	7,361	156,661	21.28	3
4	Licensed Practical Nurses	10,264	10,719	192,507	17.96	4
5	Nurse Aides & Orderlies	59,041	64,035	584,346	9.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,339	13,489	121,799	9.03	8
9	Activity Director					9
10	Activity Assistants	8,119	8,957	81,329	9.08	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,871	18,194	140,489	7.72	15
16	Dishwashers					16
17	Maintenance Workers	3,991	4,031	47,203	11.71	17
18	Housekeepers	13,466	14,783	120,045	8.12	18
19	Laundry	6,816	7,668	63,381	8.27	19
20	Administrator	2,080	2,160	94,177	43.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,179	7,781	69,053	8.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,952	2,043	19,355	9.47	31
32	Other Health C: MDS COORDIN.	1,719	1,908	35,045	18.37	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,735	165,226	$ 1,780,846 *	$ 10.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	3,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,139	10-3	39
40	Physical Therapy Consultant	L	3,009	10a-3	40
41	Occupational Therapy Consultant	Y	1,301	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,836	11-3	44
45	Social Service Consultant	E	1,556	12-3	45
46	Other(specify) DENTAL	S	3,300	10-3	46
47	PSYCHO - SOCIAL		995	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 27,076		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	15	105	10-3	52
53	TOTAL (lines 50 - 52)	15	$ 105		53

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDITH MAJCHROWICZ	ADMIN		$ 94,177
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,177

B. Administrative - Other

Description	Amount
EMI ENTERPRISES	$ 322,500
BERNARD COHEN	19,750
TOTAL (agree to Schedule V, line 17, col. 3)	$ 342,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
MAXX SOURCE	DATA PROCESSING	$ 1,500
NURSING CARE SYSTEMS	DATA PROCESSING	5,458
ALPHA DATA SYSTEM	DATA PROCESSING	3,375
LTC SOLUTIONS	DATA PROCESSING	1,320
PROFESSIONALS ASSOC	PROPERTY SURVEY	4,000
PROCLAIM AMERICA	ASSESSMENT	2,497
PERSONNEL PLANNER	UC CONSULTANT	750
KRUPNICK,BOKOR,KAGDA	ACCOUNTING	16,400
LAWRENCE SCHWARTZ	LEGAL	9,000
MCBRIDGE BAKER	LEGAL	6,078
HOLLAND & KNIGHT	LEGAL	558
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,936

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 73,131
Unemployment Compensation Insurance	10,418
FICA Taxes	135,661
Employee Health Insurance	88,835
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,045
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	7,496
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	1,460
INSURANCE - EXECUTIVE LIFE VI 21	(1,460)
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	3,201
Health Care Worker Background Check	
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,241
TRUST/FRANCHISE/CONTRIB/ETC	10,436
LICENSES & PERMITS	555
DUES & SUBSCRIPTIONS	3,322
MGMT CO ALLOCATION	825
TRUST/FRANCHISE/CONTRIB/ETC	(10,436)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(1,241)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,103

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
MGMT. CO ALLOC.	53
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 53

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FRANKFORT TERRACE # 0022889 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 2,488	3 YRS	$ 415	$ 829	$ 829	$ 415	$	$	$	$	$
2	PAINTING/DECORATIN	2000	2,634	3 YRS		439	878	878	439				
3	PAINTING/DECORATIN	2001	4,652	3 YRS			775	1,551	1,551	775			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 9,774		$ 415	$ 1,268	$ 2,482	$ 2,844	$ 1,990	$ 775	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $3,102**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,620** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,078	
				4,078
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,363	
	ELECTRICITY		32,782	
	WATER		61,250	
	CABLE TV - LOBBY		0	
			0	119,395
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		6,665	
	PAINTING & DECORATING		1,038	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,392	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,974	
	FIRE SERVICE		1,916	
			0	
			0	
			0	21,985
7	**OTHER**			
	SCAVENGER		5,234	
	SECURITY SERVICE		2,115	7,349
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	3,000	3,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	105	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		320	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	995	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2		
	PHARMACY CONSULTANT	XVIII B 39-2	6,139	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,300	
			0	10,859
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	3,009	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,301	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,310
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,836	
			0	1,836
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	1,556	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	1,556
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number FRANKFORT TERRACE **#0022889** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	342,250	342,250
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,653	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	39,283	
			0	50,936
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	3,201	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	3,322	
	LICENSES & PERMITS	XIX F	755	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,241	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	10,286	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	18,955
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		250	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		82,080	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE			
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		12,190	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		43,769	138,289

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	135,661	
	UNEMPLOYMENT COMPENSATION	XIX D	10,418	
	WORKERS COMPENSATION INSURANC	XIX D	73,131	
	HOSPITALIZATION INSURANCE	XIX D	88,835	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,045	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	1,460	
	PENSION/PROFIT SHARING PLANS	XIX D	7,496	
	CHICAGO HEAD TAX	XIX D	0	319,046
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,108	1,108
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		31,857	31,857
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		95,224	95,224
27	**OTHER**			
	BAD DEBTS	VI 24	73,503	
				73,503

GRAND TOTAL COLUMN 3 OTHER 1,251,476